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THE IMPACT OF THE AFFORDABLE CARE ACT
ON M&A OPERATIONS



Eleonora Atella – Student Nr. 2912

A Project carried out on the Master in Management, under the supervision of:
Associate Professor Adjunct – NOVA School of Business & Economics –
Doutor Duarte Pitta Ferraz

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Abstract

This empirical research studies the impact that the Affordable Care Act (ACA) had on health care beneficiaries and its impact on M&A operations in USA. It analyses the law and the results reached, attempting to answer the strategic question: “Did the Obamacare could have an influence on M&A activities?” The research based on secondary data shows an improvement in affordability and availability of insurance coverage, and a reduction of uninsured people, as well as concludes that ACA might influence M&A activities both on a quantitative way, by increasing the number of deals, as well as on a qualitative way, by increasing complexity of deals in aspects related to the due diligence process.

Key words: Affordable Care Act, M&A, Policy impact, Reform of healthcare system

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1. Introduction

The Obama administration attempts to address and improve the health care system in USA by introducing the so-called Patient Protection and Affordable Care Act (PPACA) (Gpo.gov,2016). Although USA is a country where people pay most for healthcare, findings show that when it comes to health care outcomes it fails to reach high positions by underperforming most notably for life expectancy, child mortality, number of preventable deaths, quality and efficiency (WHO, 2015).

The main objective of the research is to understand and analyze the impact that the Affordable Care Act could have on the decision of companies to merge and consolidate, as a result of the impact ACA has on beneficiaries of health care and the opportunities it generates to health care companies if they consider merging and /or consolidating operations.

To answer this question, a literature review of the principles introduced and the requirements imposed by the ACA was performed; subsequently, the research of secondary data will attempt to understand the general effects of ACA on the health care system, namely by highlighting whether or not the expected results have been reached so far. Finally, the research will be focused on the analyses of how each of those effects could impact on a company decision to merge and consolidate.

The historical data used span a 6-year period; despite such a short period since its implementation, the law appears to have already produced its effects.

2. Literature Review

Introduced in 2010, the Affordable Care Act (ACA), or Obamacare, is expected to bring positive results in terms of affordability, availability, quality and efficiency of the health care. Nevertheless, this law is raising doubts and creating concerns and uncertainties for many people especially in the way in which it could impact on M&A activities.

The Affordable Care Act has been introduced only 6 years ago. This means that so far an extensive literature that examined the impact of ACA on mergers and acquisitions activities cannot be found. However, those who have already treated this argument all agree on the fact that the Obamacare and its main effects would have some repercussions on M&A activities. Channick S., (2015), for example, evidenced how the amount of M&A deals among healthcare providers has increased especially after the implementation of the ACA; the same conclusion has been obtained by Bret Schroeder, who also added *“it appears the ACA has been the catalyst for M&A activity. Since its enactment, hospitals started merging with competitors at unprecedented rates. In 2009, pre-ACA, there were 52 announced transactions involving 80 hospitals. That number more than doubled by 2012, with 107 announced transactions involving 244 hospitals.”* (Integrated Healthcare Executive, 2016).

Christopher M. Pope agrees on the fact that the Affordable Care Act is fueling the consolidation in the health care provider industry by evidencing how The Affordable Care Act is eliminating *“many of the essential competitive checks remaining in the American health care system”* (The Heritage Foundation., 2016). M&A deals are also increasing among insurance companies; as argued by Larissa Bergin of McGuireWoods, Obamacare *“definitely encourages people to look at merger,”* (CNBC, 2015).

The fact that through this paper ultimately similar effects and consequences have been found adds robustness to those findings.

3 Discussion and Findings

3.1 The ACA and its main principles

Since insurance companies are private for-profit companies, many Americans had been left uninsured because they either could not afford it or because they were rejected due to pre-existing conditions (InterExchange, 2015). Among the others, the Obama administration attempted to address this with the Patient Protection and Affordable Care Act. The Patient

Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), or Obamacare (Gpo.gov, 2016), is the USA federal statute signed on March 23, 2010 by the President Barack Obama. It ideally represents the conclusion of the process started in 1935 by Roosevelt with the Social Security Act, and strengthened 30 years later with the introduction of Medicare e Medicaid by Johnson, with the aim of making health insurance (HI) coverage more secure, reliable and affordable for all Americans.

The main goal of ACA is then to increase the affordability, availability, quality and efficiency of the health care system in USA.

3.1.1 The healthcare system of the United States before the ACA

The U.S. health care system presents unique features when compared with those of the most advanced industrialized economies. First of all, it does not have a uniform and universal health care coverage, and does not operate via a national healthcare service (either a single-payer or a multi-payer universal health insurance fund) like in many EU countries. It can best be described as a hybrid system, where about 50 percent of U.S. health care spending come from private funds, compared to 38 percent from federal funds and 12 percent State and local funds (Kaiser Health News, 2010). Furthermore, most health care, even if publicly financed, is delivered privately. According to recent statistics (DeNavas-Walt et Al., 2013), in 2012 about 263 million people in the U.S. (84.6 percent of the U.S. population) had some type of health insurance, with 63.9 percent of workers covered by a private health insurance plan (DPE et al., 2016). Among the insured, 101.5 million people (32.6 percent of the population) received public coverage through Medicare (48.9 million), Medicaid (50.9 million), and/or VA or other military care (13.7 million) (people may be covered by more than one government plan). Finally, nearly 48 million people in the U.S. had no health insurance.

Due to this setting, in the US we can find four main categories of healthcare service users: poor people, who benefit from the Medicaid program; old people, covered by the Medicare

program; employed individuals, covered by the health insurance provided by the employer; and not insured individuals - mainly low wage workers, workers without regular employment and self-employed workers – who can still access healthcare services provided by public entities (i.e., hospitals). Besides of being a large percentage, the services they receive, as a “last resort attempt”, increase the total cost of assistance; this will translate to higher taxes and/or higher insurance premiums for the other categories.

Noticeably, the US health care system is also characterized for being the most expensive in the world, while underperforming in terms of health outcomes (most notably for life expectancy, child mortality and number of preventable deaths), quality and efficiency (WHO, 2015, Davis et Al., 2014). The reasons behind it are different: overtreatment, failures of care coordination, failures in execution of care processes, administrative complexity and so on. (Bentley, T., Effros, R., Palar, K. and Keeler, E., 2008).

3.1.2 The Affordable Care Act principles

The general goal of the Affordable Care Act is to improve the health care in America, by both increasing the affordability, the availability and the quality of the health care and making all the transformations needed to contain costs. Different ways are used.

A better affordability and availability of the healthcare services can be achieved through recognizing individual and employer responsibility. Concerning the individual responsibility, it is mandatory that every individual ensures at least a minimum amount of coverage, the absence of which translates in a penalty of \$95 in 2014, \$495 in 2015 and \$750 in 2016, or up to 2% of income by 2016, with a cap at the national average bronze plan premium (see Americaoutdoors.org).¹ Concerning the employer responsibility, the law makes distinctions according to the number of employees it has. In particular, starting from January 1 2015,

¹ According to this section, families with children, with a cap of \$2,250 for the whole family, should pay only half the amount. The subtitle, however, recognizes some exceptions, i.e. people that cannot have a coverage because of religious or financial availability reasons, Indian tribe members, incarcerated individuals.

every employer with 50+ full-time equivalent (FTE) employees has to offer health insurance coverage to their employees, or to face some penalties for noncompliance.²

Important are also the new rules of the new marketplace that will be established. Known as “Exchange” it will allow individuals and small-employer groups to purchase for themselves and for their employees the ACA health coverage required. For this reason, starting in October 1, 2013, employers have been forced to notify every single new employee hired.

To guarantee availability, the ACA prohibits insurers to refuse insurance coverage to individuals because of particular pre-existing medical conditions and to discriminate in the provision of the health plan premium rates. In fact, according to the ACA insurance plans and premiums can vary only according to “family structure, geography, actuarial value, tobacco use, participation in a health promotion program, and age” (see <http://www.dpc.senate.gov/docs/lb-111-1-151.html>). Lastly, better affordability and availability can be reached also through the refundable tax credits, for those people with incomes between 100 and 400 percent of the federal poverty line (FPL), and through the reduced cost-sharing for individuals enrolling in the so-called qualified health plans.³ Subtitle D of the ACA introduces and explains the concept of a “qualified health plan”.⁴ For the same reason several changes have been introduced to the existing Public Programs, such as Medicaid and the Children’s Health Insurance Program.

Improvements in the quality of the healthcare sector are instead pushed by linking the payment to quality outcomes, by strengthening the quality of infrastructure and by introducing a set of initiatives aimed at orienting the nation’s health care system towards the health promotion and disease prevention and by encouraging recruiting and training the

² Penalties are applied according to the number of employees.

³ Specific rules on the application of those tax credits are also present for small businesses with “fewer than 25 workers for up to 50 percent of the total premium cost” (Obamacarefacts.com, 2016).

⁴ According to Sec.1301 of the ACA, a Qualified plan is a plan “certified by Exchanges, which provides the essential health benefits package, and be offered by licensed insurers that offer at least one qualified health plan at the silver and gold levels” (Obamacarefacts.com, 2016). In other words, a qualified health plan is a plan that is certified by the Health Insurance Marketplace and that provides essential health benefits, that follow some established limits on cost-sharing and that have a specific actuarial value (which defines how much the insurer pays).

healthcare workforce supply. The creation of a National Quality Strategy, the establishment of a Center for Quality Improvement and Patient Safety or the authorization of new payment and delivery models are examples of some of ACA efforts to improve the quality of the health care system in USA. Lastly, to improve the efficiency of the health care, the ACA intends to offer some financial rewards to the providers who are able to cut costs due to inappropriate care and to encourage the creation of Accountable Care Organizations (ACOs), which are “network of doctors and hospitals that shares financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending” (Kaiser Health News, 2016). For those organizations, the Obamacare recognizes the possibility to receive some bonuses if they deliver services in an efficient way.⁵

3.2 The ACA’s results after 6 years

The main goal of the Affordable Care Act is to improve the health care outcomes of Americans, by increasing affordability, availability and quality of the health care services provided and by implementing all transformations needed to contain costs. Even if from an historical perspective a 6-year period after the introduction of the ACA represents a very short time for a throughout evaluation, the aim with this section is to collect available evidence for an analysis of whether or not those goals have been reached.

3.2.1 Has insurance become more affordable and available under the new law?

Before the ACA, in the absence of an insurance coverage obtained through their employers, individuals were able to choose whether or not to buy it on their own. Willing to buy it, however, they had to sustain the full cost of the premium; in addition, in presence of pre-existing conditions, they had to pay higher costs or, even worse, to see their conditions excluded from their coverage. As such, this system showed to be inefficient.

⁵ The bonuses and all the features related to them vary according to the form of ACO it is refer to (Medicare ACOs - including Pioneer ACOs and Shared Savings Program ACOs - ACOs organized by hospitals, by physicians, by payers and so on).

The Affordable Care Act has been thought to resolve this inefficiency problem. And it seems to work. According to a survey conducted by the Commonwealth Fund, in 2010 around 19 million individuals found that the Individual Insurance market was not an affordable option (Commonwealthfund.org, 2010). As a consequence, many people were uninsured or underinsured (Commonwealthfund.org, 2011). Thanks to ACA, in 2015 the number of enrollments increased to 23 millions, among which around 10 millions enrolled in the marketplace; the remaining group refers to individuals who now have an insurance coverage thanks to Medicaid expansion, or to other coverage provisions or to their parents' plans. Among the 10 million individuals enrolled in the marketplace; about 84% are able to pay the premiums thanks to federal tax credits; and, of this percentage 56% were subject to cost-sharing subsidies (Commonwealthfund.org, 2015).

Surveys also found that individuals with low income who bought their insurance coverage through the marketplace reported premium costs similar to those with employer coverage, thanks to the premium tax credits. In this case, the subsidized coverage options made the individual market coverage as affordable as the one provided by employers.

However, this positive effect is true only for individuals with low or moderate incomes (with an annual salary less than \$30,000). In fact, it is important to remember that the law requires insurance companies to provide many additional benefits and to cover individuals with pre-existing conditions. This has caused an increase in premiums offered by insurance companies (Freedompartners, 2016). For this reason, while the low income people gained advantages through the ACA (they see their premiums be reduced or totally offset by government helps), those with higher income (approximately between \$30,000 and \$47,000 for a single person) found, when present, the subsidies too small (Goldstein, 2014, Commonwealth.org, 2015). In fact, as a consequence of the phase-out of the premium tax credits, these individuals now pay higher premiums compared to those paid by individuals with employer health benefits.

From this analysis it then seems that for some individuals the ACA led to an increase in the affordability of insurance coverage (at least for those with low or medium income).

It is important to highlight that the figures presented above consider the law costs and benefits only from the consumers' point of view. However, as economic theory teaches, there are not free lunches and those benefits do not come for free; conversely, they are paid by the government and potentially will re-paid back through higher taxes. A Bloomberg Government report has shown that the ACA legislation costs to taxpayers about \$73 billion, an amount that “has *far exceeded anyone's estimates (or imaginations)*” and that, according to the Congressional Budget Office, will likely increase in the next years (Bloomberg.com, 2014).⁶

This extra expenditure should be balanced by extra revenues or by cuts in other sectors.

Overall, this leads to conclude that if on one hand the ACA seems to work in terms of increasing the affordability of insurance coverage, on the other it has a large impact in terms of redistributive effects, making the system more progressive and equitable; this is probably one of the main causes of the large opposition it has faced during its approval process.

3.2.2 Has the percentage of uninsured people been reduced?

Thanks to the changes brought by ACA, the number of uninsured has fallen significantly. According to a survey conducted by CDC/NCHS, adults aged 18-64 who did not have an insurance coverage in 2010 were 22,3%, while uninsured children under age 18 were 7.8% (Robin A. and all, 2011). After the implementation of the Affordable Care Act, the amount of uninsured adults aged 18-64 started to decrease being in March 2015 only 13% (Cohen, R. and Martinez, M., 2015). More in detail, the analysis of the Gallup-Healthways Well-Being Index survey data carried out by the office of Assistant Secretary for Planning and Evaluation (APSI), shows that the major coverage expansions due to this Act began at the end of 2013. From October 2013 (when the Open Enrollment started) through the end of 2015, around 17.7

⁶ For the 2017–2026 period, the projected net cost of those provisions is forecasted around \$1.4 trillion. For more details see: <https://www.cbo.gov/publication/51385#section2>

millions of nonelderly adults – aged between 18 and 64 – gained health insurance coverage through early 2016, by reducing the uninsured rate for non-elderly adults by 7,4% (Uberoi, N., Finegold, K. and Gee, E., 2016). Concerning the number of uninsured children, instead, it decreases to 4.6% (Robin A. and all, 2015).

A survey conducted by the RAND Corporation shows, instead, that the total amount of uninsured Americans now dropped from 42.7 million to 25.8 million (Rand.org, 2016). Lastly, other different numbers are observed in the Statista website, when comparing the number of uninsured people with and without (Statista, 2016) the Affordable Care Act from 2015 to 2025 (in millions of nonelderly people).

Summarizing, it is then possible to affirm that even if the exact number of people affected by the law is not consistent, all the sources agree on the fact that this number is now lower.

3.2.3 Did the Affordable Care Act improve health outcomes?

Even if Americans are widely known for paying healthcare high costs, findings show that they do not receive the care services they need; even worse, sometimes they receive care that causes harm (Blumenthal, D., Stremikis, K. and Cutler, D., 2013). Often this occurs because the care they receive is in general delivered too late and/or with lack of clinical appropriateness and, sometimes, inefficiently and unevenly across populations.

Besides of making health care services affordable and available, ACA also aims to improve the overall quality of the system by implementing several actions. One of them is the introduction of the Hospital Readmissions Reduction Program (HRRP). By reducing the payments to hospitals that show higher-than-expected rates of readmissions of Medicare beneficiaries within 30-days, the ACA aims to improve the quality of services provided. Data show that from 2007 to 2015, readmission rates for targeted conditions declined from 21.5% to 17.8% (New England Journal of Medicine, 2016). This translates to over 70,000 fewer preventable hospital readmissions.

Another evidence of the improvement in the health care quality can be identified by considering that many life (about 50,000 patients) and billions of dollars (\$12 billion) have been saved thanks to a 17% reduction in the country Hospital-Acquired Conditions (HAC).⁷ By expanding a previous program introduced by the CMS, the ACA has been able to reduce the HAC rates per 1,000 discharges from 145 in 2010 to 121 in 2014 (Agency for Healthcare Research and Quality, 2014).

Besides of the above incentives, the ACA created some other Medicare payment incentives for hospitals and for healthcare providers in general (e.g. the In-Patient Value-Based Purchasing Program or the the In-Patient Value-Based Purchasing Program). Even if those “pay-for-performance programs” are surrounded by many critics (Committee for Economic Development of The Conference Board, 2016; The Heritage Foundation, 2013), it seems that they increase the quality in the healthcare sector.

In order to improve the quality of the system, the ACA also introduced the Accountable Care Organizations (ACOs). By aiming at providing a more coordinate care to their patients, these organizations are eligible for some bonuses when they deliver care more efficiently or, in other words, when they are able to lower costs while meeting performance standards on care quality. To receive those bonuses, an ACO must first demonstrate that it meets the quality performance standard published every year by the Centers for Medicare & Medicaid Services (CMS). Differences in those standards can be identified, among the others, according to the ACO program they refer to (two types of programs: the Medicare Shared Savings Program and the Pioneer ACO Model - for experienced health care organizations in coordination of care across care settings). By imposing those quality standards for those organizations, the CMS is indirectly operating and increasing the quality of the health care system in general.

⁷ The HAC rates per 1,000 discharges declined from 145 in 2010 to 121 in 2014. For more details see: <http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/pfp/interimhacrate2014.pdf>

Even if the quality of the healthcare system cannot be easily measured, it is possible to assume that it is increased as a consequence of the increased amount of ACOs that have met those quality standards recently.⁸ For example, in 2015 Pioneer ACOs improved on 28 of the 33 quality measures by experiencing an average improvements of 3.6% across all quality measures, while Shared Savings Program ACOs improved on 30 of them (Cms.gov, 2016). The existence of ACOs shifts then the focus from quality to quantity.

Moreover, the fact that the ACA ties Medicare Advantage bonus payments to the quality of coverage these private plans offer has improved the range of higher-quality Medicare Advantage plan from which beneficiaries can choose from. In 2013, the 14 million Medicare beneficiaries enrolled in Medicare Advantage had access to 127 four- and five-star plans, which is 21 more high-quality plans than were available in the previous year. In 2015 this percentage increased reaching 97% (Kff.org, 2016).

As caveat, we should remember that even if all those initiatives have been introduced, the small period of the ACA implementation experienced so far makes quite difficult to identify with precision the ACA's effects and results on the quality of the healthcare system.

3.2.4 Has the law contributed to a slowdown in health care spending?

Among the many goals, the ACA has been conceived to reduce the rate at which the U.S. health care spending was growing, while enhancing access and health outcomes. Based on data from the Centers for Medicare & Medicaid Services (see Appendix 2), despite the national health expenditures increased from \$2,157.0 billions in 2006 to \$3,031.3 billions in 2014, its rate of growth, computed as a 4 year-average before and after the introduction of ACA, decreased from 4.8% to 3.9%. This reduction was mainly due to the slowdown in Medicare spending growth that for the period 2009 - 2012 grew at an average rate of 1.8%

⁸ data are not yet definitely available, however, studies show that patients report better care experiences in some respects than Medicare beneficiaries who are not part of ACOs. More detail available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4239654/>

annually (the average rate for the period 2000-2008 was 5.9%) and in 2013 at an average rate of 0.2% (Aspe.org, 2015). However, it is important to highlight that the slower growth in national health expenditures is in line with the rate of overall economic growth for four years, from 2009–10 through 2013–14 (Commonwealthfund.org , 2016).

Then, for the period 2010 - 2013, the ACA was able to reach this goal. However, in 2014, the path has been completely overturned: the U.S. health care spending increased by 5.3%, reaching \$3031,3 trillion (Cms.org, 2014). The reasons behind it are different. In 2014, spending for hospital care, physician and clinical services and other professional and dental services have, in fact, all experienced an increase in their growth rate, increasing respectively by 4.1% (\$971.8 billion), 4.6% (\$603.7 billion), 5.2% (\$84.4 billion) and 2.8% (\$113.5 billion). The path was also due to the increase in the spending growth for freestanding home health care agencies, (4.8%). Mainly, the faster growth in 2014 was attributable to increased spending by the two largest payers of home health, Medicare (+3.3%) and Medicaid (+3.5%). Five years after its approval, there are strong indicators that the ACA has had a positive impact on the expenditure as well as on insurance coverage. However, the longer-term impact on the economy and the nation's ability to maintain the ACA's achievements will likely depend on what will happen to health care costs and whether effective policies evolve to sustain slow cost growth.

3.3 How does the ACA impact on M&A operations

The several initiatives introduced in the health care sector by the ACA have brought many consequences in the health care industry, which could potentially affect, in a direct or indirect way, the M&A activities in both a quantitative and qualitative way.

3.3.1 The quantitative impact of ACA on M&A operations

Because of its new principles, the ACA could impact in many different ways on the decisions of companies to merge and consolidate. Beyond the healthcare providers and the healthcare insurance companies, the law may influence also the decision to merge of companies beyond the healthcare sector. The following sections will then analyze more in detail how some of the ACA principles could affect the number of M&A activity.

3.3.1.1 M&A activities among healthcare providers

Among all providers in the health care sector, those who play the main important role are by far the hospitals and the doctors. In what follows an exam of the role that the ACA could have on these groups will be conducted.

Among the many, the two basic thrusts of the ACA that affect the supply side of the health care system are that of reforming the healthcare delivery system and expanding health insurance. Concerning the reform of the healthcare delivery system, a first point to highlight is that the ACA has changed the way in which services providers (e.g. hospitals) are reimbursed: while before 2010 services providers were paid for each service they provide (i.e., fee-for service model), they are now paid through a lump-sum payment for various services. In this way, healthcare providers could have difficulties in overcome the costs of the services provided and fail in breakeven, by probably forcing them, to look for mergers and acquisitions, operations through which they can increase their market share and reduce costs.

The change in the way in which services providers are reimbursed, as well as, the presence of pay-for-performance programs will force healthcare providers to increase their workforce. A study conducted by the Center for Workforce Studies Association of American Medical Colleges shows a shortage in every health care profession and the increase in the demand for this type of laborers will render the current situation even worse (Aamc.org, 2012). The need to meet some quality standards and the increase in the amount of people insured would for sure make the workforce shortages catastrophic (Heritage.org, 2014). In fact, without a strong

and growing workforce operating under better working conditions, the quality of patient care will not improve. This would then increase stress on individuals, organizations, and systems, and push for M&A activities. Hospitals, individual physicians and other health care entities are merging and consolidating to remain strong in the marketplace (Boston.com, 2016).

The path towards M&A activities is also pushed by the fact that the law is encouraging all healthcare providers to organize themselves in the form of ACOs. M&A deals are ways through which they can try to establish themselves as or to participate in an ACO.

Summarizing we can thus say that, even if those mergers would have been probably happened anyway, the Affordable Care Act has accelerated their speeds and increased their impacts.

The way in which ACA is impacting on M&A activities should be taken into account. In fact, while hospital mergers could help creating economies of scale, a highly concentrated market is not desirable from a societal perspective. In fact, those mergers are not good for consumers and for the government, since they could lead to higher prices for them. According to the New England Journal of Medicine, “the last hospital merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit” (Nejm.org, 2014).

Paradoxically, in this way ACA could indirectly lead to higher prices and costs and this does not result in any value added neither for the patient nor for the system. This means that not only the law may not be able to meet the initial intended goals, but potentially could produce a final result that is worse than the one before the ACA itself. Indeed, it has been showed that the rate of patients who died because of heart attack is higher in hospital markets that are dominated by few providers (Kessler, D. and McClellan, M., 1999).

3.3.1.2 M&A activities among healthcare insurance companies

Taking in consideration what said so far, because of the ACA, many hospitals and healthcare providers could decide to merge to be able to sustain the higher costs and risks of ACA. By merging, they could then try to increase their market power. In order to counterbalance the

increase in the healthcare providers' market power, many insurance companies could then decide to use the same strategy and merge. (*The Heritage Foundation.*, 2016).

In fact, the bargaining power of insurance companies on healthcare providers (e.g. hospitals), depends on the market power that the latter have: the more their market power, the less the possibility for insurance companies to exclude them and the higher the possibility for the healthcare providers to impose higher prices without the risk to be excluded. This is particularly true if health insurance companies are fragmented. This could put insurers at a disadvantage to negotiate prices and push them towards M&A deals.

In addition, as we have seen so far, through the Obamacare the number of uninsured people decreased. More in particular, the U.S Department of Health and Human services (HHS) showed that in the first months of March 2016, around 20.0 million were the uninsured adults who have gained health insurance coverage thanks to ACA. As a consequence, insurance companies have experienced an increase in their revenues. In fact, while in 2010 the revenues of health insurance companies in U.S were 644.76 billion U.S. dollars, in 2014 this amount increased to 663 billion U.S. dollars and reached 696 billion U.S. dollars in 2016 (Statista, 2016; Ibisworld.com, 2016). In this respect the sector remains one of the few who has easily recovered from the losses of the 2007 recession and has further improved.

However, it is important to highlight that a similar performance cannot be seen in their profit margins. In fact, even if revenues are higher, margins have remained flat. The main reason behind this is represented by the ACA's rule on the Minimum Loss Ratio (MLR), "*a key financial measure that shows the percentage of premium dollars a health insurer pays for medical care and health care quality improvement expenses, as opposed to the portion allocated to overhead in the form of profits, administrative costs, and sales expenses*" (Commonwealthfund.org, 2012). If an insurer collects \$100,000 in premiums and spends 60% on medical care, 60% is the percentage it has to spend on healthcare claims and quality

improvement (MLR); 40% can then be dedicated to administration, marketing and profit. The ACA imposes insurance companies to have an annual, minimum MLR of 80% for individual and small group insurance plans, and 85% MLR for large group plans (spend respectively 80% and 85% of premiums on healthcare).⁹ This requirement has squeezed the profit margins of many insurance companies (e.g. Assurant Health¹⁰). M&A operations could then be one smart way to see margins grow (e.g. Anthem – Cigna).

ACA has also added many constraints on health insurance plans and additional complications. Firstly, under the ACA, insurers are not allowed to refuse coverage because of pre-existing conditions. This reduce their ability to manage risk and drive up the insurance companies' costs. Secondly, the increase in the regulation leads to an increase in the compliance costs.¹¹ Rather than through an internal growth, companies could decide to increase their margins and to minimize the costs through M&A deals. Robust sources of data show that companies are already following this path. The Common Wealth Fund has identified that the four main firm concentration ratios for the sale of private insurance increased from 74% to 83% between 2006 and 2014 (Coomonwealthfund.org, 2012).

2.3.1.3 M&A activities among companies outside the health care industry

The Affordable Care Act may have consequences that go well beyond the health care sector. As explained before, the employer mandate requires employers with 50 or more FTE employees to provide them health insurance coverage starting in 2015. This means that the total amount of insurance premiums that the companies will have to pay will be high: they have to purchase health insurances for their employees, and guarantee that this insurance provides unlimited lifetime coverage and unlimited annual coverage (ACA's requirement). The Obama administration estimates that these mandates alone could increase premiums for

⁹ Section 1001 of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended).

¹⁰ More details available at <http://dailysignal.com/2015/05/04/after-expanding-under-obamacare-this-123-year-old-insurance-company-is-closing-its-doors/>

¹¹ As explained see later, this has led to an increase in the premiums offered.

some businesses by 7%. Employers that maintain insurance plans are already purchasing coverage for dependent children without any waiting periods for preexisting conditions. In addition, the ACA also mandates that employers maintain coverage for dependents up to age 26. In addition, this situation is exacerbated by the fact that, because of the ACA most probably the premiums asked by the insurance companies will rise (Kff.org, 2015). This could lead some companies to sell and increase deals.

At the same time, however, the ACA imposes that companies should notify employees of the affordable marketplace or provide them with an ACA-compliant plan. However, especially in this second case, companies are subjected to different rules according to the number of employees they have. For this reason, problems and issues may then arise when a company decides to merge with another company. A merger according to which a company with less than 50 employees combines with another company that makes the first one to cross this threshold, may create many difficulties and problems to them, by imposing an immediate change to the company's employee benefits to ensure healthcare rules and regulations are met. This has led many companies to change their consideration about a possible deal so that some of them have decided to call off their deals. As highlighted by Wright and Kelley, two attorneys at Minneapolis-based Gray Plant Mooty, companies may decide to renounce to their M&A plans in order to avoid to pay the *“potential health care penalties or would require them to make benefit changes themselves”* (Tcbmag.com, 2013).

3.3.2 The qualitative impact of ACA on M&A operations

The ACA could affect M&A deals both on a quantitative and qualitative point of view; In fact, it could have an important role also on some aspects on how to perform some steps of a merger. When a merger occurs, especially in a stock sale, the buyer acquires also all the responsibilities and liabilities for the benefit plans planned by the target company. Not considering this aspect may expose the parties to important risks that could affect the success

of the transaction. What is important is then dedicate time and effort to include the consideration of those aspects both in the pre and post-steps of an M&A operation.

Among the others, one of the new issues that should be considered refers to the “Due Diligence” information. For example, the ACA requires a possible target company to acquire group health plans with new specific characteristics; however, it also allows them to maintain the pre-acquired program, if preferred. Those pre-existing plans (e.g. “Grandfathered plans”, “Premium reimbursement plan”, “Health reimbursement arrangements”), are exempt from compliance with some of the insurance-market reform. For this reason, an addition step in the due-diligence process should be dedicated to specify, analyze and verify the characteristics of those plans and ensure that those plans are still categorize as such. For example, a plan that is erroneously believed to be grandfathered, will likely have violated one or more insurance-market reforms and will expose the buyer to significant excise taxes.

Another important issue of the ACA is the employer shared-responsibility mandate, which, as explained before, should be analyzed very carefully in the pre-merger step; by not considering it could create many future problems and costs for the company.

Careful considerations should be dedicated also to how to obtain some measures. An example of this is to how a company evaluates whether or not an employee is a full-employee subject to the employer mandate. If the measurement used by the target company is different from the one used by the buyer, a merger between those two companies may lead to the presence of an inconsistency between those measurements *ex ante* and *ex post* the merger. This inconsistency may cause many problems for the buyer. In order to avoid those problems, the companies should agree on this aspect in the letter of intent.

4. Conclusions

To improve the American health care, well known for showing low quality compared to the high investments, in 2010 the Obama administration introduced the Patient Protection and

Affordable Care Act (PPACA). Through different initiatives and requirements, PPACA intends to improve affordability, availability, quality and efficiency of the health care system, which, as the research demonstrates, is costly and full of market failures that include overtreatment, failure of care coordination, on top of administrative complexity.

Although the ACA was implemented 6 years have, research shows that positive results have been achieved in terms of affordability, availability of insurance coverage and reduction in the number of uninsured people. In terms of affordability and availability, although with the impact of selected negative “redistributive effects”, research from secondary data shows that the Act seems to lead to an improvement in affordability and availability of insurance coverage, namely for those with low and medium income. Concerning the number of uninsured people, even if the exact total amount of uninsured Americans is not consistent among the different secondary sources, most agree on the fact that there has been a reduction in the number of uninsured people.

In terms of limitations of the research carried, the results and evaluation of the impact of the on health quality and efficiency of the health care system are not sufficiently available and/or measurable or robust. Nevertheless, secondary data is enough to predict the potential impact ACA will have, namely in the decisions of the companies that consider and decide to merge and consolidate. Particularly, secondary data shows an increase in the number of deals among health care providers, as well as among insurance companies; conversely, the impact on companies outside the healthcare sector is still uncertain. Lastly, is relevant to analyze the impact of ACA on the due-diligence process, namely because of the increasing complexity resulting from new regulation on the specifications PPACA brought to the industry.

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